2008 Benefits At A Glance

In-Network Benefits	COVA Care You Pay	COVA HDHP You Pay	Kaiser Permanente You Pay
Deductible – per plan year			
• One person	$200	$1,200	None
• Two or more persons	$400	$2,400	None
Out-of-pocket expense limit – per plan year			
• One person	$1,500	$5,000	None
• Two or more persons	$3,000	$10,000	None
Doctor's visits			
• Primary Care Physician	$25	20% after deductible	$10
• Specialist	$35	20% after deductible	$10
Hospital services			
• Inpatient	$300 per stay	20% after deductible	$100 per admission
• Outpatient	$100 per visit	20% after deductible	$10 per visit
Emergency room visits	$100 per visit (waived if admitted)	20% after deductible	$50 per visit (waived if admitted)
Outpatient diagnostic laboratory, tests, shots and x-rays	10% after deductible	20% after deductible	$10 physician, x-ray and diagnostic services $0 lab, pathology, radiology, diagnostic testing
Prescription drugs – mandatory generic			
• Retail Pharmacy	*Up to 34-day supply:* $15/$20/$35	20% after deductible	*Up to 60-day supply* • Kaiser On-Site Pharmacy.....$10 • Community Pharmacy $20
• Home Delivery Pharmacy	*Up to 90-day supply:* $30/$40/$70	20% after deductible	*Up to 90-day supply* • Mail Service.....$8
Wellness & Preventive Services			
• Through age 6	*Office visits at specified intervals, immunizations, lab and x-rays* $0	$0	$0
• Age 7 and older	*Annual checkup visit (Primary Care Physician or Specialist)* $0 *Immunizations, lab and x-rays* $0	$0 $0	$0 $0
• Specified ages	*Routine gynecological exam, Pap test, mammography screening, prostate exam (digital rectal exam), prostate specific antigen test (PSA), and colorectal cancer screening.* $0	$0	$0

In-Network Benefits	COVA Care You Pay	COVA HDHP You Pay	Kaiser Permanente You Pay
Basic Dental	Plan year deductible: $50 single $100 dual, $150 family	Plan year deductible: $50 single $100 dual, $150 family	Plan year deductible: $25 per member
Plan Year Maximum Per Member	Balance after plan pays $2,000	Balance after plan pays $2,000	Balance after plan pays $1,000
Diagnostic and Preventive	$0, no deductible	$0, no deductible	See fee schedule
Primary (Basic) Care	20% after deductible	20% after deductible	See fee schedule
Expanded Dental *Complex Restorative (inlays, onlays, crowns, dentures, bridgework)*	Optional*: 50% after deductible	Included: 50% after deductible	Included: See fee schedule
Orthodontic • Lifetime max per member	50%, no deductible Balance after plan pays $2,000	50%, no deductible Balance after plan pays $2,000	See fee schedule Balance after plan pays $1,000 (age 19 and under)
Out-of-Network Option*	Plan payment is reduced by 25%. Provider may balance bill for amount above allowable charge.	Not available	Not available
Vision & Hearing Options*			
Vision (once every 24 months)		Not available	
• Routine eye exam	$35		$10 per visit
• Eyeglass frames	Balance after plan pays $75		25% discount
• Lenses			
• One pair single lenses, or	Balance after plan pays $50		
• One pair bifocal lenses, or	Balance after plan pays $75		
• One pair trifocal lenses, or	Balance after plan pays $100		
• Contact lenses (any kind)	Balance after plan pays $100		15% discount on initial pair
Hearing (once every 48 months)		Not available	Not available
• Routine hearing exam	$35		
• Hearing aids and other hearing aid related services	$0		
• Benefit Maximum	Balance after plan pays $1,200		

***** *Options are offered for an additional premium.*

This is an overview of your health care benefits. For details, see the appropriate Member Handbook or plan document, or visit ***www.dhrm.virginia.gov****.*